

Editorial

Depression: a major public health problem in need of a multi-sectoral response

Many international investigations have identified depression as a significant contributor to the burden of disease¹. Its high life-time prevalence, associated disability, chronic course and recurrence have been highlighted. Its frequent association with other common chronic medical conditions (*e.g.* diabetes mellitus, angina, asthma, arthritis, *etc.*) and the incremental worsening of their outcomes have been documented². Its contribution to suicide is widely recognised. Depression is acknowledged as a major public health problem by many national governments and international agencies.

Disease burden

Mental disorders contribute to 13 per cent of the global burden of disease, with major depression expected to be the largest contributor to this by 2030¹. The economic impact of this burden is significant with mental disorders expected to cost nearly a third of the projected US\$ 47 trillion incurred by all non-communicable diseases. Indian data also support the contention that depression contributes significantly to disease burden in the country. Many studies have documented that about a quarter of patients attending outpatient departments of general hospitals suffer from diagnosable common mental disorders including depression and anxiety³. A meta-analysis of community surveys estimated the prevalence of depression and anxiety to be about 33 per thousand population⁴. The high rates of suicide documented in different parts of the country also document extreme mental distress⁵.

Diagnosis of depression

A diagnosis of depression, when viewed through the biomedical lens, tends to suggest disease, supposes a central nervous system aetiology and pathogenesis,

documents signs and symptoms, offers differential diagnoses, recommends pharmacological therapies and prognosticates about the course and outcome. However, the diagnosis of depression poses some challenges. The absence of laboratory tests to diagnose the condition has forced psychiatrists to rely on clinical symptoms and signs. The absence of pathognomonic symptoms has meant the use of clinical syndromes for diagnosis.

An attempt to improve the reliability of diagnosis resulted in the introduction of operational criteria in the 1970s. Despite refinement over the past four decades, these are symptom checklists⁶. The criteria essentially count symptoms of depression with little regard for context, stress, personality and coping. Epidemiological studies of depression use diagnostic instruments, which do not evaluate stress related conditions and fail to address short-term adjustment problems⁶. The marginalisation of short-term stress-related adjustment disorders in clinical practice is due to the elastic concept of depression and the rigid application of the diagnostic hierarchy and criteria. Consequently, people with depression secondary to disease, normal people under severe stress and those who cope poorly with the usual demands of life, can qualify for a diagnosis of major depression⁶. The use of symptom counts for the diagnosis, focus on cross-sectional presentations and refusal to factor the context (stress, coping, supports) are limitations of the current diagnostic criteria. The heterogeneity of the label, high rates of spontaneous remission and of placebo response and the limited response to medication in milder depression⁷ argue against the sole use of antidepressant treatment. The more recent management guidelines advocate support and psychological intervention for mild and moderate forms of depression⁸.

Separating human distress from depression is difficult⁹. The depression seen in the community is often viewed as a result of personal and social stress, lifestyle choices or as a product of habitual maladaptive patterns of behaviour. Consequently, the general population and general practitioners often hold psychological and social models for depression. Psychiatrists, with their biomedical frameworks, on the other hand, argue for disease models for these conditions. They transfer the disease halo reserved for melancholia and severe mental illness to all psychiatric diagnoses. While psychiatrists argue that depression is easily recognised using simple screening instruments, general practitioners contend that these screens identify people in distress rather than those with disease. Many have argued against the medicalisation of personal, social and economic distress.

Public health implications

Many studies have documented the link between poverty and common mental disorders such as depression and anxiety. They have demonstrated a consistent relationship with low education¹⁰. The experience of insecurity and hopelessness, rapid social change, risk of violence and physical illness are postulated as links between poverty and poor mental health¹⁰. Poor mental health worsens the economic situation, setting up a vicious cycle of poverty and mental disorders.

Female gender is also a risk factor for depression¹¹. Social determinants have a significant impact on the health of girls and women in general and on depression in particular. Most studies on depression document that women are at a higher risk for depression when compared with men. Young women are also overrepresented among those who commit suicide in India¹². Gender injustice is a major issue for women in traditional patriarchal societies. Social exclusion and cultural conflicts can also contribute to mental ill health and depression.

Consequently, there is a need to move beyond urgency-driven medical solutions and incorporate public health perspectives, policies and approaches in managing depression and common mental disorders¹³. The sole focus on medical solutions is an error of the public health movement in low and middle-income countries as it mistakes primary care for public health. Public health is often reduced to a biomedical perspective. Consequently, much of the efforts of the champions of public health end up in the provision of

curative services, albeit at the small hospital, clinic or at the village level. Public health requires the inputs from diverse disciplines (*e.g.* politics, finance, law, engineering, religion, *etc.*) and is much more than biomedical perspectives and solutions¹⁴. Such approaches should intervene at the population level in order to bring about the necessary revolution.

Multi-sectoral intervention

The medical/psychiatric, psychological, social and economic causes of depression argue for a multi-factorial aetiology for the condition. Such a perspective calls for a multi-sectoral understanding of depression and mental health. It argues for a multi-pronged approach to intervention. Within such a framework, pure medical and psychiatric approaches to depression would be restrictive and ineffectual for the vast majority of depression seen in the community. While severe and melancholic depression demands antidepressant medication and psychiatric treatment, milder forms of the condition respond to psychological support, social solutions and economic initiatives. Population interventions involving social and economic approaches would be mandatory for improving the mental health of a significant proportion of population with depression.

Investments in education and provision of microcredit, in addition to reducing poverty, are recommended for their collateral benefits in reducing the risk of mental disorders¹⁰. Population-based strategies of meeting basic needs of clean water, sanitation, nutrition, immunization, housing, health and employment and initiatives for gender justice have been suggested as strategies to reduce distress and suicide¹⁵. Programmes to reduce social exclusion and discrimination, a reduced social class gradient and a more equal society will also help reduce emotional distress and depression. The social determinants of health apply to mental health as well.

Rhetoric and reality

India pushed through a resolution on mental health at the recently concluded 65th World Health Assembly¹⁶. The resolution acknowledged the magnitude of the global burden of mental illness. It recognised its negative impact on individuals, families, society and on the economy. It accepted the need for recognition and treatment of mental illness, for efforts to reduce stigma and discrimination and to reintegrate people with mental health problems into society. It exhorted

member states to take up the challenge and provide a comprehensive and co-ordinated response for addressing issues related to mental health.

India's rhetoric on mental health needs to be backed by fundamental changes in its approach. The task calls for wisdom and broad-based and multi-sectoral response to managing depression and mental disorders in the population. It also demands a radical departure from the failed strategies of the past with their sole focus on psychiatric treatment. It calls for a multi-sectoral response, which also involves social and economic approaches and interventions. There is a need for a broad-based response to improve mental health of the population and an urgent need to convert rhetoric into reality.

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